HealthShare Exchange (HSX) Patient Opt-Out Form

Consumers may use this form to request that their healthcare information NOT be included in the health information exchange (HIE) activities of HealthShare Exchange (HSX), the HIE organization for the Greater Philadelphia and Delaware Valley areas, including southeastern Pennsylvania and southern New Jersey.

In HIE, participating healthcare providers exchange patient health and healthcare information, in a secure and confidential way, for purposes of providing care to patients. The health information of individual who submit this Opt-Out Form will NOT be accessible to healthcare providers and other authorized users through the HIE. HSX participants who search for such information will receive a message informing them that the individual has opted out.

This request does not prohibit the individual’s healthcare provider from otherwise disclosing the individual’s medical information based on other authorizations and applicable law, or by other methods.

Individuals who have opted out can choose to participate in the HIE again at any time by using the Opt-Back-In Form at https://www.healthshareexchange.org/patient-options-opt-out-back or by calling (855) 479-7372 (HSX-SEPA) or emailing consent@healthshareexchange.org.

This form supersedes any previously submitted Opt-Back-In Forms to HSX. Therefore, HSX participants who search for information on the individual submitting this form will not receive healthcare information upon request.

Submission of Opt-Out Form

The HSX Opt-Out Form can be completed online at: https://www.healthshareexchange.org/patient-options-opt-out-back

In addition, HSX will accept either the HSX Opt-Out Form or the PA Patient and Provider Network OPT-Out or OPT-BACK-IN FORM by email to consent@healthshareexchange.org, or by fax submission to 215-422-4333, or through postal mail to:

HealthShare Exchange
American College of Physicians Building
190 N. Independence Mall West, Suite 701
Philadelphia, PA 19106
attention: Consent Management Department
To opt out, please fill out the information below and submit this form:

**Patient Information**

First Name*  
Middle Name  
Last Name*  
Maiden Name (If Applicable)  
Current Address*  
Current City*  
Current State*  
Current Zip Code*  
Current Country*  
Primary Phone Number*  
Secondary Phone Number  
Current Email Address  
Date of Birth*  
(mm/dd/yyyy)  
Gender*  
Social Security Number or Last Four Digits  

* Required Information

**Parent or Guardian Information (if applicable)**

First Name  
Last Name  
Primary Phone Number  
Current Email Address  
Relationship

Submitter’s statement: In completing this Opt-Out Form, I verify that I am the person named above, or I am legally authorized to complete this form for the person named above. The information provided on this form, and the preferences expressed herein, are accurate to the best of my abilities. Date: ________________________

**Notification of Opt Out**

Person’s submitting this Opt-Out Form, have the right to be notified that their opt out has been completed. Please indicate preferred method of notification:

- phone
- letter
- no notification

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